Please
MOSAIC
Engaging Newcomers, Enriching Communities

Fax: 604-262-0571

Referral for clients to MOSAIC Mental Health Services

Referral Date (mm/dd/yy): _____

Referred by (your name): _____ MOSAIC Program: _____

Referrers email: _____ Referrers work phone: _____

I confirm that the client has consented to this referral ☐

Client's Information

Last Name: _____ First Name: _____ Middle initial(s): _____

DOB (dd/mm/yyyy): _____

Gender: M ☐ W ☐ transgender ☐ non-binary ☐ other ☐ Sex as listed on gov't ID: M ☐ F ☐ X ☐

BC MSP: _____ IFHP_____ ☐ other Prov insurance_____ ☐ Private Insurance ☐ Uninsured

Preferred Phone Number: _____ Email Address: _____
May we email? Yes ☐ No ☐

Client's Address: _____ City: _____ Postal Code: _____
☐ patient does not have an address

Client's preferred language(s): _____

The client requires services in a language other than English Y ☐ N ☐ **Language for interpreter:** _____

Reason for referral (*please note any previous diagnosis of mental illness if known*):

_____

_____

_____

_____

Is the client looking for…

One to one counselling ☐ Group counselling ☐ Referral ☐ Information ☐

Other ☐ _____

Note: Counselling is a confidential service. Counsellors can only share information (including appointment times) with the referrer on an as needed basis, and if the client signs a Release of Information.

DISCLAIMER: We are not a crisis service. If your client is in crisis and requires immediate help, please call 9-1-1 or direct them to the nearest emergency department.
Alternatively, you can call crisis line at 310-6789 (no area code needed).